		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019976

Facility Name: The Henry and Jane Vonderlieth Living Center

Address: 1120 North Topper Drive (Number) Mount Pulaski (City) 62548 (Zip Code)

County: LOGAN

Telephone Number: (217) 792-3218 **Fax #** (217) 792-3210

IDPA ID Number: 37-0967671001

Date of Initial License for Current Owners: 10/21/73

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Helen M. Meagher **Telephone Number:** (217) 735-2549

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Cindy Russell
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Helen M. Meagher, C.P.A.
(Firm Name & Address) Helen M. Meagher, C.P.A.
101 1/2 S. Kickapoo, Lincoln, IL 62656
(Telephone) (217) 735-2549 Fax # (217) 732-8315

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,940	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	956	2,065		3,021	8
9	SNF/PED					9
10	ICF	6,733	20,618		27,351	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,689	22,683		30,372	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.20%

D. How many bed-hold days during this year were paid by Public Aid?
97 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/21/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cen # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	232,107	20,941	8,221	261,269	(47,435)	213,834		213,834			1
2	Food Purchase		166,885		166,885	(31,284)	135,601	(2,296)	133,305			2
3	Housekeeping	106,971	18,580		125,551		125,551		125,551			3
4	Laundry	39,733	10,818		50,551		50,551		50,551			4
5	Heat and Other Utilities			107,301	107,301		107,301		107,301			5
6	Maintenance	58,159	14,534	35,196	107,889	1,789	109,678	(4,202)	105,476			6
7	Other (specify):* SEE PAGE 24			2,923	2,923	(1,516)	1,407		1,407			7
8	**TOTAL General Services**	436,970	231,758	153,641	822,369	(78,446)	743,923	(6,498)	737,425			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,073,741	69,478	62,239	1,205,458	(4,982)	1,200,476		1,200,476			10
10a	Therapy	42,128		3,729	45,857		45,857		45,857			10a
11	Activities	51,615	5,337	6,515	63,467		63,467		63,467			11
12	Social Services	19,359		7,346	26,705		26,705		26,705			12
13	Nurse Aide Training	8,060		1,042	9,102	4,982	14,084		14,084			13
14	Program Transportation			2,834	2,834		2,834		2,834			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,194,903	74,815	83,705	1,353,423		1,353,423		1,353,423			16
	C. General Administration											
17	Administrative	57,327		3,025	60,352	(1,789)	58,563	(1,203)	57,360			17
18	Directors Fees			3,101	3,101		3,101		3,101			18
19	Professional Services			4,885	4,885		4,885		4,885			19
20	Dues, Fees, Subscriptions & Promotions			22,241	22,241	650	22,891	(4,848)	18,043			20
21	Clerical & General Office Expenses	68,682	13,901	8,733	91,316		91,316		91,316			21
22	Employee Benefits & Payroll Taxes			299,217	299,217	78,069	377,286		377,286			22
23	Inservice Training & Education			330	330		330		330			23
24	Travel and Seminar			6,362	6,362		6,362		6,362			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,587	17,587		17,587		17,587			26
27	Other (specify):*											27
28	**TOTAL General Administration**	126,009	13,901	365,481	505,391	76,930	582,321	(6,051)	576,270			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,757,882	320,474	602,827	2,681,183	(1,516)	2,679,667	(12,549)	2,667,118			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center #0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			199,820	199,820	(42,923)	156,897	6,109	163,006			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,643	3,643		3,643	(3,643)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,516	1,516		1,516			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			203,463	203,463	(41,407)	162,056	2,466	164,522			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			40	40		40		40			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,410	49,410		49,410		49,410			42
43	Other (specify):* SEE PAGE 24			19,738	19,738	42,923	62,661	(62,661)				43
44	**TOTAL Special Cost Centers**			69,188	69,188	42,923	112,111	(62,661)	49,450			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,757,882	320,474	875,478	2,953,834		2,953,834	(72,744)	2,881,090			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,296)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,153	30		9
10	Interest and Other Investment Income	(3,643)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,234)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,614)	20		28
29	Other-Attach Schedule SEE WORKSHEET PAGE 5A	(67,110)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (72,744)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (72,744)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Henry and Jane Vonderlieth Living Center

ID# 0019976

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Current year deferred maintenance	$ (13,098)	6	1
2	Write off prior years deferred amintenance	8,896	6	2
3	Apartment expenses	(62,661)	43	3
4	Flowers	(1,178)	17	4
5	Investment expense	(25)	17	5
6	Loss on equipment disposal -- not fully depreciated	956	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(67,110)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center **#** 0019976 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,296)	0	0	0	0	0	0	0	0	0	0	(2,296)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,202)	0	0	0	0	0	0	0	0	0	0	(4,202)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,498)	0	0	0	0	0	0	0	0	0	0	(6,498)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,203)	0	0	0	0	0	0	0	0	0	0	(1,203)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,848)	0	0	0	0	0	0	0	0	0	0	(4,848)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,051)	0	0	0	0	0	0	0	0	0	0	(6,051)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,549)	0	0	0	0	0	0	0	0	0	0	(12,549)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,109	0	0	0	0	0	0	0	0	0	0	6,109	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,643)	0	0	0	0	0	0	0	0	0	0	(3,643)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,466	0	0	0	0	0	0	0	0	0	0	2,466	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(62,661)	0	0	0	0	0	0	0	0	0	0	(62,661)	43
44	**TOTAL Special Cost Centers**	(62,661)	0	0	0	0	0	0	0	0	0	0	(62,661)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(72,744)	0	0	0	0	0	0	0	0	0	0	(72,744)	45

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cen # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cent # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Farmer's Bank of Mt. Pulaski		x	Working capital	N/A	12/13/99	40,000		06/12/00	0.0600	1,197	6
7	Farmer's Bank of Mt. Pulaski		x	Working capital	N/A	01/26/00	20,000		06/12/00	0.0600	454	7
8	Farmer's Bank of Mt. Pulaski		x	Working capital	N/A	06/12/00	60,000	60,000	06/12/01	0.0600	1,993	8
9	TOTAL Facility Related						$ 120,000	$ 60,000			$ 3,643	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 120,000	$ 60,000			$ 3,643	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	None	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,140 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

25 apartments owned by corporation

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building & Grounds	2,163,000	1971	$ 55,924	1
2					2
3	TOTALS	2,163,000		$ 55,924	3

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1973	$ 1,172,276	$ 29,307	35	$ 33,494	$ 4,187	$ 864,733	4
5	30		1977	1977	441,636	11,041	35	12,618	1,577	291,003	5
6											6
7											7
8											8
	Improvement Type**										
9	Heating system			1979	3,848		20			3,848	9
10	Conversion			1979	11,345	344	33	344		7,390	10
11	Medicine room			1981	474	24	20	24		472	11
12	Fence			1981	921		8			921	12
13	Sidewalks			1981	1,209	60	20	60		1,168	13
14	Shower room			1982	1,175	34	35	34		626	14
15	Blacktopping			1983	5,095	255	20	255		4,420	15
16	Landscaping			1984	1,000		10			1,000	16
17	Remodeling			1984	3,117	156	20	156		2,587	17
18	Parking lot			1985	36,890	1,234	15	1,234		36,890	18
19	Fire hydrant			1985	1,308	39	15	39		1,308	19
20	Building improvement			1985	5,201	173	30	173		2,659	20
21	Energy management system			1985	9,381	470	20	469	(1)	7,159	21
22	Blacktopping			1986	3,885	194	20	194		2,797	22
23	Shrubs			1986	583		10			583	23
24	Sewer lift station			1986	40,129	2,006	20	2,006		28,251	24
25	Sewer lift station			1987	15,420	771	20	771		10,730	25
26	Windows improvements			1988	4,721		5			4,721	26
27	Fan			1988	1,743		5			1,743	27
28	Office remodeling			1988	1,580	105	15		(105)		28
29	Sealcoating			1989	4,580	305	10		(305)	4,580	29
30	Patio door			1990	985	66	15	66		671	30
31	Trees			1990	700	64	10	64		700	31
32	Air conditioner			1991	53,731	3,582	15	3,582		34,328	32
33	Building improvements (ceilings, lift station, temperature controls)			1991	16,133	1,613	10	1,613		15,116	33
34	Building improvements (kitchen floor, sprinklers, fire doors)			1991	43,767	2,918	15	2,918		28,110	34
35	Fire alarm panels			1992	4,622	308	15	308		2,721	35
36	TOTAL (lines 4 thru 35)				$ 1,887,455	$ 55,069		$ 60,422	$ 5,353	$ 1,361,235	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water softner			1992	7,887	789	10	789		6,838	9
10	Walk-in cooler			1992	12,469	623	20	623		5,036	10
11	Door monitor system			1992	1,700	170	10	170		1,374	11
12	30 Heating units			1992	9,810	491	20	491		4,296	12
13	Library paneling			1993	3,900	195	20	195		1,479	13
14	Convection units			1993	3,270	164	20	164		1,257	14
15	Asphalt sealcoating			1994	2,809		5	10	10	2,809	15
16	Computer room			1994	2,244	224	10	224		1,475	16
17	Roof			1995	324,374	12,975	25	12,975		76,568	17
18	Pump			1995	3,439	344	10	344		2,035	18
19	Room size heater			1995	1,604	160	10	160		947	19
20	Heating system units			1995	9,772	977	20	489	(488)	2,771	20
21	Garage doors			1996	1,550	155	10	155		685	21
22	80 Gallon water heater			1996	7,611	761	10	761		3,298	22
23	Therapy, activity, administration offices, and additional storage			1998	796,976	22,770	35	22,770		62,618	23
24	Exhaust fan			1998	1,691	169	10	169		507	24
25	Additional finish costs (line 23 above)			1998	4,715	135	35	135		371	25
26	Dampers and motor actuator			1998	3,293	165	20	165		481	26
27	Chiller			1998	14,853	743	20	743		2,167	27
28	Moveable wall			1998	9,830	393	25	393		884	28
29	Boiler programmer			1998	2,570	129	20	129		376	29
30	80 Gallon water heater			1998	5,287	529	10	529		1,455	30
31	Chain link fence			1999	1,019	68	15	68		102	31
32	Lowered "one head"			2000	2,087	87	10	87		87	32
33	8 Steel universal access doors 24"x24"			2000	437	18	10	18		18	33
34	11 Smoke & fire dampers			2000	21,450	358	10	358		358	34
35	Card zone expander installed			2000	3,185	53	10	53		53	35
36	TOTAL (lines 4 thru 35)				$ 1,259,832	$ 43,645		$ 43,167	$ (478)	$ 180,345	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Floor tile for center corridor & dining room			2000	6,290	35	15	26	(9)	26	9
10	Blacktopping			1992	2,859		10	286	286	2,574	10
11	Garbage disposal (replaced in 1999) DELETED			1995			5				11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 9,149	$ 35		$ 312	$ 277	$ 2,600	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 533,696	$ 48,810	$ 48,811	$ 1	5-15 yrs	$ 283,334	37
38	Current Year Purchases	11,333	1,091	1,091		5-15 yrs	1,091	38
39	Fully Depreciated Assets	195,564	1,080	1,080		5-15 yrs	195,564	39
40								40
41	TOTALS	$ 740,593	$ 50,981	$ 50,982	$ 1		$ 479,989	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	1983 Chevrolet Van	1987	$ 9,225	$	$	$		$ 9,225	42
43	Patient Transport	1992 Buick LeSabre	1992	20,742					20,742	43
44	Patient Transport	2000 Chev Supreme Bus	1999	43,000	7,167	7,167		6	8,959	44
45										45
46	TOTALS			$ 72,967	$ 7,167	$ 7,167	$		$ 38,926	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	4,025,920	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	156,897	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	162,050	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	5,153	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	2,063,095	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apartment Land Improvements	$ 55,894	$ 2,308	$ 44,996	52
53	Apartments	1,396,936	39,504	559,895	53
54	Art & Portrait	15,000			54
55	Equipment	16,356	1,111	8,060	55
56					56
57	TOTALS	$ 1,484,186	$ 42,923	$ 612,951	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	99

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
HOURS PER AIDE	44

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		492		492
3	Classroom Wages (a)	124	5,485		5,609
4	Clinical Wages (b)		2,451		2,451
5	In-House Trainer Wages (c)		4,982		4,982
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		550		550
9	TOTALS	$ 124	$ 13,960	$	$ 14,084
10	SUM OF line 9, col. 1 and 2 (e)	$ 14,084			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 368,786	$	1
2	Cash-Patient Deposits	3,688		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	123,337		3
4	Supply Inventory (priced at FIFO cost)	14,371		4
5	Short-Term Investments	2,620,261		5
6	Prepaid Insurance	12,533		6
7	Other Prepaid Expenses	3,659		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	21,773		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,168,408	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,924		13
14	Buildings, at Historical Cost	4,434,962		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	844,914		16
17	Accumulated Depreciation (book methods)	(2,560,969)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements, Hist. Cost	171,443		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,946,274	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,114,682	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 51,909	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,688		28
29	Short-Term Notes Payable	60,000		29
30	Accrued Salaries Payable	88,893		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,993		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 206,483	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Apartment Resident Deposits	1,124,421		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,124,421	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,330,904	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,783,778	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,114,682	$	48

***(See instructions.)**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,847,978	1
2	Restatements (describe):		2
3	**Restate investments from historical cost to fair market value**	954,285	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,802,263	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(18,485)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (18,485)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,783,778	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,560,707	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,560,707	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	2,106	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,106	23
	D. Non-Operating Revenue		
24	Contributions	183,998	24
25	Interest and Other Investment Income***	135,332	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 319,330	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Apartment Income**	54,162	28
28a	**Loss on disposal of equipment**	(956)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 53,206	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,935,349	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	822,369	31
32	Health Care	1,353,423	32
33	General Administration	505,391	33
	B. Capital Expense		
34	Ownership	203,463	34
	C. Ancillary Expense		
35	Special Cost Centers	19,778	35
36	Provider Participation Fee	49,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,953,834	40
41	**Income before Income Taxes (line 30 minus line 40)****	(18,485)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (18,485)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,098	2,306	$ 47,349	$ 20.53	1
2	Assistant Director of Nursing	710	734	15,160	20.65	2
3	Registered Nurses	9,174	9,651	167,359	17.34	3
4	Licensed Practical Nurses	20,230	21,721	294,604	13.56	4
5	Nurse Aides & Orderlies	52,402	55,976	487,141	8.70	5
6	Nurse Aide Trainees	1,565	1,565	8,060	5.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,357	3,707	42,128	11.36	8
9	Activity Director	2,124	2,300	24,373	10.60	9
10	Activity Assistants	3,256	3,609	27,242	7.55	10
11	Social Service Workers	2,193	2,446	19,359	7.91	11
12	Dietician					12
13	Food Service Supervisor	1,925	2,135	26,573	12.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,879	24,563	205,534	8.37	15
16	Dishwashers					16
17	Maintenance Workers	4,320	4,907	58,159	11.85	17
18	Housekeepers	12,356	13,308	106,971	8.04	18
19	Laundry	3,934	4,309	39,733	9.22	19
20	Administrator	2,186	2,331	57,327	24.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,191	2,415	34,476	14.28	23
24	Clerical	3,399	3,601	34,206	9.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,464	5,959	62,128	10.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,763	167,543	$ 1,757,882 *	$ 10.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	195	$ 8,221	1 (3)	35
36	Medical Director				36
37	Medical Records Consultant	2	60	10(3)	37
38	Nurse Consultant	379	18,699	10 (3)	38
39	Pharmacist Consultant	1	50	10 (3)	39
40	Physical Therapy Consultant	81	3,729	10a (3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	109	7,346	12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	767	$ 38,105		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	17	$ 1,913	10 (3)	50
51	Licensed Practical Nurses	1,157	38,670	10 (3)	51
52	Nurse Aides	40	861	10 (3)	52
53	TOTAL (lines 50 - 52)	1,214	$ 41,444		53

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Russell	Current administrator	0	$ 27,710
Warren Dick	Former administrator	0	29,617
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,327

B. Administrative - Other

Description	Amount
Flowers $1178; Copier expense $1789; Corp franchise fee $5;	$ 2,972
Notary public $10; ; Investment fee $25;	35
Safe deposit box rent $18	18
TOTAL (agree to Schedule V, line 17, col. 3)	$ 3,025
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Helen M. Meagher, CPA	Audit, cost report & 990	$ 4,840
Harris & Harris	Legal	45
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,885

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,956
Unemployment Compensation Insurance	3,124
FICA Taxes	131,561
Employee Health Insurance	88,305
Employee Meals	78,719
Illinois Municipal Retirement Fund (IMRF)*	
Worker's Compensation Deductible	4,929
Employee Physicals	2,216
Employee Awards	7,170
Hepatitis Shots	128
Fruit/Snacks for Employees	3,178
TOTAL (agree to Schedule V, line 22, col.8)	$ 377,286

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,399
Health Care Worker Background Check	
(Indicate # of checks performed 54)	650
Life Services Network of IL	3,699
MES/HPSI	145
Facility Advertising	4,848
Administrator License Fee	150
Less: Public Relations Expense	( )
Non-allowable advertising	(4,848)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,043

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SEE PAGE 25	3,075
Seminar Expense	
SEE PAGE 25	3,287
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,362

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Water Pump Replaced	Nov-93	$ 4,068	5	$ 814	$ 814	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
2	Sewer Lift Station Repairs	Aug-93	4,066	5	813	813	0	0	0	0	0	0	0
3	Circulating Pump Repairs	Apr-94	2,156	5	431	431	165	0	0	0	0	0	0
4	Hand Rail Installed	Jun-94	4,791	5	958	958	480	0	0	0	0	0	0
5	Van Paint & Repairs	Nov-95	3,081	3	1,027	856	0	0	0	0	0	0	0
6	Gazebo Repairs	Jul-96	1,612	5	322	322	322	322	163	0	0	0	0
7	Generator Repairs	Jul-96	1,528	5	306	306	306	306	177	0	0	0	0
8	Water Heater Mixing Brd	Jan-97	3,892	5	778	778	778	778	780	0	0	0	0
9	Parking Lot Sealcoat	Jul-97	7,009	5	701	1,402	1,402	1,402	1,402	700	0	0	0
10	Repair Chiller	Aug-97	1,917	5	160	383	383	383	383	225	0	0	0
11	Paint & Wallpaper	Oct-98	3,234	3	0	270	1,078	1,078	808	0	0	0	0
12	Repair Walk-in Freezer	Sep-99	1,746	5	0	0	116	349	349	349	349	234	0
13	Vinyl Wallcoverings	Jul-99	14,358	5	0	0	1,436	2,872	2,872	2,872	2,872	1,434	0
14	Chiller Compressor replac	Jun-00	5,789	5	0	0	0	675	1,158	1,158	1,158	1,158	482
15	Blacktopping Drive	Jul-00	7,309	5	0	0	0	731	1,462	1,462	1,462	1,462	730
16													
17													
18													
19													
20	TOTALS		$ 66,556		$ 6,310	$ 7,333	$ 6,466	$ 8,896	$ 9,554	$ 6,766	$ 5,841	$ 4,288	$ 1,212

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of IL, $3699**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **19,331** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **49,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **78,719** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **2,296**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Helen M. Meagher, C.P.A.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

V. COST CENTER EXPENSES

A. General Services		Other
Line 7 Other:		
Waste Removal	$	93
Hazardous Waste Removal		1,314
Rent - storage building		1,516
	$	2,923
E. Special Cost Centers		
Line 43 Other:		
Apartment Expenses:		
Maintenance		7,899
Utilities		2,250
Trash Removal		1,008
Cable		2,655
Insurance		4,835
Supplies		755
Fruit for residents		336
	$	19,738

V. RECLASSIFICATOINS

	Description	To Line	From Line	Amount
1	Employee Meal Costs	22		78,719
			1	(47,435)
			2	(31,284)
2	Nurse Aide Training Costs:	13		4,982
	Trainer Wages		10	(4,982)
3				
3	CDS Copier Service	6		1,789
			17	(1,789)
4	Apartment Depreciation	43		42,923
			30	(42,923)
5	Employee Background Checks	20		650
			22	(650)
6	Storage Shed Rental	34		1,516
			7	(1,516)

XIX. SUPPORT SCHEDULES

G. Schedule of Travel and Seminar

Description	Amount
In-State Travel	
Occ., Rehab., and Training Conference - lodging and meals	$ 138
LSNT Conference - travel, lodging, meals	2,809
Employee local auto use reimbursement	128
TOTAL In-State Travel	$ 3,075

Seminar Expense	Date	Location	
Illinois Nursing Home Administrators Associati	02/18/00		$ 230
Career Track	02/18/00	Springfield	179
Azer Clinic - ORT Conference	03/01/00	Knoxville	295
Life Services Network of IL	03/21/01	Chicago	1,910
Life Services Network of IL	04/24/00	Peoria	65
SIU - 5th Annual Alzheimers Disease Conferenc	05/17/00	Springfield	300
Outcome Services of IL	06/01/00	Springfield	58
IAPA Conference	09/13/00	Rockford	150
SIU - Alzheimers Disease & Dementias Conf.	09/22/00	Springfield	75
Lincoln, IL Health Department	10/19/00	Lincoln	25
TOTAL Seminar Expense			$ 3,287